RECORDS REQUEST BY JIM PHILLIPS, Jr. D.M.D.

761 North Dean Road
Auburn, AL 36830
(334) 821-5291
(334) 821-5292 Fax
info@drphillipsdental.com

HIPPA AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Request records from: _____

_____

_____

I authorize and request that the above office release a copy of all recent x-rays and current records to Jim Phillips, Jr. D.M.D.

PATIENT NAME: _____

PATIENT'S DATE OF BIRTH: _____

A copy of this Authorization may be used in place of and with the same force and effect as the original. This Authorization is made by the patient or the patient's legal representative.

By providing this Authorization:

1. I understand that the health information to be released to Jim Phillips, Jr. D.M.D., will continue to be protected by state and/or federal privacy rules and that my treatment is not considered on this authorization.

2. I understand that I may revoke this authorization at any time by written notification, but such revocation by me will have no effect on disclosures of information already made under this authorization prior to the receipt of my revocation.

3. I understand that this authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information until the expiration date noted below.

This authorization will expire (6) months from the date set forth below.

Signature of Patient or Patient's Legal Representation: _____

Date: _____